NC Medicaid Pharmacy Prior Approval Request
Sedative Hypnotics

Beneficiary Information

1. Beneficiary Last Name:		2. Beneficiary First Name:	
3. Beneficiary ID#:		4. Beneficiary Date of Birth:	
5. Beneficiary Gender:			

Prescriber Information

6. Provider NPI#:		7. Provider Last Name:	
8. Requestor Contact Name:		9. Requestor Contact Phone# and Extension:	

Drug Information

10. Drug Name:		11. Drug Strength:	
12. Quantity per 30 days:		13. Length of Therapy:	☐Up to 30 days ☐60 ☐90
			☐120 ☐180 ☐other_____

Clinical Information

Request for Non-Preferred Drug

☐ Failed two (2) preferred drugs. If only one (1) is available, then failed one preferred drug.	List preferred drugs failed, and reason failed:
☐ Previous episode of an unacceptable side effect or therapeutic failure with preferred drug(s).	Please provide clinical information:
☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug (s).	Please provide clinical information:
☐ Age specific indications for non-preferred agent.	Please give beneficiary age and explain:
☐ Unique clinical indication supported by FDA approval or peer reviewed literature.	Please explain and provide a reference:
☐ Unacceptable clinical risk associated with therapeutic failure.	Please explain:

Criteria for Exceeding Quantity Limits (check all that apply)

1. Does beneficiary have a diagnosis of chronic primary insomnia lasting one month or longer? ☐ Yes ☐ No	2. Has beneficiary received information on good sleep hygiene and had a documented trial (at least 3 weeks) of non-pharmacological therapies (ex. stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy)? ☐ Yes ☐ No
3. Does beneficiary have diagnosis of chronic secondary or co-morbid insomnia lasting one month or longer and has been evaluated for and is being actively treated for one of the below conditions? ☐ Yes ☐ No Please check appropriate condition: ☐a. underlying psychiatric illness associated with insomnia ☐b. underlying medical illness associated with insomnia (ex chronic pain associated with cancer, inflammatory arthritis etc.) ☐c. sleep disorder such as restless legs syndrome, sleep-related breathing disorder, sleep related movement disorder, or circadian rhythm disorder	4. Is beneficiary being discontinued from a sedative hypnotic and tapering is required to prevent symptoms of withdrawal? ☐ Yes ☐ No 5. Is beneficiary being actively assessed for a diagnosis of chronic primary or secondary/co-morbid insomnia? ☐Yes ☐ No (Do not check "yes" if answer to #1 above is "yes")

Signature of Prescriber: _____ Date: _____

**Prescriber Signature mandatory*

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to NCTracks at (855) 710-1969
DMA-0022

Pharmacy PA Call Center: (866) 246-8505